

**State of Vermont
Division of Disability and Aging Services
TBI Program**

INDIVIDUAL SERVICE PLAN

Evaluation Due Date: _____ **Today's Date:** _____

Consumer Name: _____ **SSN:** _____

Address: _____

Guardian: _____

Guardian Phone Number: _____ **Alternate Phone Number:** _____

Guardian Address: _____

Program: ☐ Long Term OR ☐ Rehabilitation

DOB: _____ **Date of Injury:** _____ **Services Start Date:** _____

Provider Agency: _____

Case Manager: _____ **Phone Number:** _____

Other Insurance Information: _____

Client Summary: (Include a discussion of strengths, needs, current environment, natural supports, etc.)

Funded Services:

- | | | |
|---|--|--|
| <input type="checkbox"/> Life Skills Aide | <input type="checkbox"/> Case Management | <input type="checkbox"/> Community Supports |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Psych & Counseling Supports | <input type="checkbox"/> Employment Supports |

Other Services: (Example: counseling, medication management, SLP, OT, PT, AA)

Safety Precautions/Functional Activity:

<input type="checkbox"/> No restrictions	<input type="checkbox"/> Contract PRN
<input type="checkbox"/> Self Administration of Medications	<input type="checkbox"/> Suicide Precautions
<input type="checkbox"/> Constant Observation	<input type="checkbox"/> Restrict driving
<input type="checkbox"/> Transport to:	
<input type="checkbox"/> Other:	

☐ Supervision level: _____

Diagnoses: _____

Medications and Dosage: (Attach additional sheet if necessary)

Medication	Dosage	Purpose	Prescribing Physician:

Allergies: _____

Advance Directives: ☐ Yes OR ☐ No

Diet / Nutrition Needs: _____

Long Term Outcomes: (Refer to Independent Living Assessment for developing specific goals under each outcome)

Improved Physical Development and Mobility

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Improved Communication / Cognitive Skills

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Improved Eating Behaviors

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Improved Food Preparation / Cooking Ability

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Improved Personal Hygiene and Grooming

•

Improved Health and Safety Behaviors

•

Improved Social Behaviors and Leisure Time

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Individual Service Plan

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Improved (ADL's) and Household Chores

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Improved Budgeting and Numerical Skills

-

Improved Transportation and Travel

-

Vocational Skills:

-

Discharge Plan:

Consumer input:

Consumer: _____ Date:_____

Guardian: _____ Date:_____

(if applicable)

Case Manager: _____ Date:_____